

SERFF Tracking Number:	PERR-125627554	State:	Arkansas
Filing Company:	Guarantee Insurance Company	State Tracking Number:	## \$50
Company Tracking Number:	GIC-WC-AR-08-F		
TOI:	16.0 Workers Compensation	Sub-TOI:	16.0004 Standard WC
Product Name:	Policy Jacket - Dec page revision		
Project Name/Number:	GIC-WC-AR-08-F/GIC-WC-AR-08-F		

## Filing at a Glance

Company: Guarantee Insurance Company

Product Name: Policy Jacket - Dec page revision

SERFF Tr Num: PERR-125627554 State: Arkansas

TOI: 16.0 Workers Compensation

SERFF Status: Closed

State Tr Num: ## \$50

Sub-TOI: 16.0004 Standard WC

Co Tr Num: GIC-WC-AR-08-F

State Status: Fees verified

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Carol Stiffler, Brittany Yielding

Authors: Faviola Jimenez, Lois Pimentel

Disposition Date: 05/05/2008

Date Submitted: 05/02/2008

Disposition Status: Approved

Effective Date Requested (New): 06/01/2008

Effective Date (New): 06/01/2008

Effective Date Requested (Renewal): 06/01/2008

Effective Date (Renewal):

State Filing Description:

## General Information

Project Name: GIC-WC-AR-08-F

Status of Filing in Domicile: Authorized

Project Number: GIC-WC-AR-08-F

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 05/05/2008

State Status Changed: 05/05/2008

Deemer Date:

Corresponding Filing Tracking Number: N/A

Filing Description:

On behalf of Guarantee Insurance Company ("Guarantee") we are submitting this form filing. Guarantee has recently re-domesticated from South Carolina to Florida. The enclosed documents reflect the current address and phone number of Guarantee.

For completeness, we are submitting all of the extensions and schedules that accompany the declarations page. As a member of NCCI, Guarantee has elected to utilize the NCCI forms that have been submitted and approved in your state

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on Guarantee's behalf. This filing supplements the NCCI forms.

Guarantee proposes to implement this filing for all policies effective on or after June 1, 2008.

The rate impact of this filing is 0.0%.

Enclosed is authorization for Perr&Knight to submit this filing on behalf of the Company. All correspondence related to this filing should be directed to Perr&Knight. The Company has prepared the forms contained in this filing. If there are any requests for additional information related to items prepared by the Company, we will forward the request immediately to the Company. We will submit the Company's response to your attention as soon as we receive it.

Please do not hesitate to contact us should you have any questions or concerns.

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - perrandknightactuaryconsultants)

Lois Pimentel, State Filings Project Coordinator doi@perrknight.com

Perr&Knight (888) 201-5123 [Phone]

Pacific Palisades, CA 90272 (310) 230-8529[FAX]

### Filing Company Information

Guarantee Insurance Company	CoCode: 11398	State of Domicile: Florida
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401 East Las Olas Boulevard	Group Code:	Company Type:
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Suite 1540

Ft. Lauderdale, FL 33301	Group Name:	State ID Number:
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(954) 670-2900 ext. [Phone]	FEIN Number: 22-2222789
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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	AR filing fee is \$50 per form submission

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<b>Per Company:</b>	<b>No</b>		

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Insurance Company	\$0.00	05/02/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
102653	\$50.00	05/01/2008

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved	Carol Stiffler	05/05/2008	05/05/2008

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## **Disposition**

Disposition Date: 05/05/2008

Effective Date (New): 06/01/2008

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	Filing Memorandum, Letter of Authorization	Approved	Yes
Form	Workers Compensation and Employers Liability Insurance Policy	Approved	Yes
Form	Workers Compensation and Employers Liability Insurance Policy Information Page	Approved	Yes

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## Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Workers Compensation and Employers Liability Insurance Policy	WC 00 00 00 A	None	Policy/Coverage Form	Replaced Form #:0.00 Previous Filing #:		WC000000A.pdf
Approved	Workers Compensation and Employers Liability Insurance Policy Information Page	WC 00 00 01A	None	Declaration Replaced s/Schedule	Replaced Form #:0.00 Previous Filing #:		WC000001A.pdf

**WORKERS COMPENSATION AND  
EMPLOYERS LIABILITY INSURANCE POLICY**

**GUARANTEE INSURANCE COMPANY**  
A Stock Company

**FORT LAUDERDALE, FLORIDA**  
401 E. Las Olas Boulevard, Suite 1540  
Fort Lauderdale, Florida 33301

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THESE POLICY PROVISIONS WITH THE INFORMATION PAGE AND ENDORSEMENTS,  
IF ANY, ISSUED TO FORM A PART THEREOF, COMPLETE THIS POLICY.

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# WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY QUICK REFERENCE

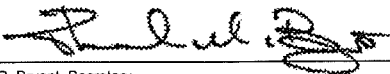
	BEGINNING ON PAGE		BEGINNING ON PAGE
<b>INFORMATION PAGE</b>			
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B. Who Is Insured	1	H. Recovery From Others	4
C. Workers Compensation Law	1	I. Actions Against Us	4
D. State	1	<b>PART THREE-OTHER STATES INSURANCE</b>	4
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<b>PART TWO-EMPLOYERS LIABILITY INSURANCE</b>	2	F. Records	5
A. How This Insurance Applies	2	G. Audit	5
B. We Will Pay	2	<b>PART SIX-CONDITIONS</b>	6
C. Exclusions	3	A. Inspection	6
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**IMPORTANT:** This Quick Reference is **not** part of the Workers Compensation and Employers Liability Insurance Policy And does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Insurance Policy itself for actual contractual provisions.

**PLEASE READ THE POLICY CAREFULLY.**

In Witness Whereof, we have caused this policy to be executed and attested, and, if required by state law, this policy shall not be valid unless countersigned by our authorized representative.

  
\_\_\_\_\_  
Steven Mariano, Chief Executive Officer

  
\_\_\_\_\_  
Theodore G. Bryant, Secretary

## WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

## GENERAL SECTION

**A. The Policy**

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

**B. Who is Insured**

You are insured if you are an employer named in item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

**C. Workers Compensation Law**

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

**D. State**

State means any state of the United States of America, and the District of Columbia.

**E. Locations**

This policy covers all of your workplaces listed in items 1 or 4 of the Information Page; and it covers all other workplaces in item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE  
WORKERS COMPENSATION INSURANCE**A. How This Insurance Applies**

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

**B. We Will Pay**

We will pay promptly when due the benefits required of you by the workers compensation law.

**C. We Will Defend**

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

**D. We Will Also Pay**

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

**E. Other Insurance**

We will not pay more than our share of benefits and costs covered by this insurance and other

insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

#### F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

#### G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

#### H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the

workers compensation law that apply to:

- a. benefits payable by this insurance;
  - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

## PART TWO EMPLOYERS LIABILITY INSURANCE

### A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

### B. We Will Pay

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed

against such third party as a result of injury to your employee;

2. for care and loss of services; and
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

### C. Exclusions

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Conti-

ental Shelf Lands Act (43 USC Sections 1331-1356), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901-942), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;

9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. bodily injury to a master or member of the crew of any vessel;
11. fines or penalties imposed for violation of federal or state law; and
12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

### D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

### E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

**F. Other Insurance**

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

**G. Limits of Liability**

Our liability to pay for damages is limited. Our limits of liability are shown in item 3.B. of the Information Page. They apply as explained below.

1. **Bodily Injury by Accident.** The limit shown for "bodily injury by accident-each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. **Bodily Injury by Disease.** The limit shown for "bodily injury by disease-policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease-each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

**H. Recovery From Others**

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

**I. Actions Against Us**

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and

2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

### PART THREE OTHER STATES INSURANCE

**A. How This Insurance Applies**

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.
4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

**B. Notice**

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

### PART FOUR YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal

papers related to the injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

## PART FIVE - PREMIUM

### A. Our Manuals

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

### B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

### C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

### D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

### E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is cancelled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancellation table and procedure. Final premium will not be less than the minimum premium.

### F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

### G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

**PART SIX - CONDITIONS****A. Inspection**

We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

**B. Long Term Policy**

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

**C. Transfer of Your Rights and Duties**

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

**D. Cancellation**

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice.
4. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

**E. Sole Representative**

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY  
INFORMATION PAGE**

NCCI Co. No.

20850

**Guarantee Insurance Company**

A Stock Company

**Fort Lauderdale, Florida**

401 E. Las Olas Boulevard, Suite 1540

Fort Lauderdale, FL 33301

866-827-4669

Policy No.

Renewal of Policy No.

1. The Insured/Mailing address:

☐ Individual      ☐ Partnership

☐ Corporation or \_\_\_\_\_

Insured's I.D. No(s)., if applicable

FEIN: \_\_\_\_\_

Other workplaces not shown above: **See Schedule**

2. The policy period is from \_\_\_\_\_ to 12:01 A.M. Standard Time, at the  
insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in item 3.A. The limits of our

liability under Part Two are: Bodily Injury by Accident \$\_\_\_\_\_ each accident

Bodily Injury by Disease \$\_\_\_\_\_ policy limit

Bodily Injury by Disease \$\_\_\_\_\_ each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any listed here:

D. This policy includes these endorsements and schedules: **SEE SCHEDULE OF ENDORSEMENTS**

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per \$100 or Remuneration	Estimated Annual Premium
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**See Item 4. Extension WC 00 00 01 A**

If indicated below, interim adjustments of premium shall be made -  <input type="checkbox"/> Semiannually; <input type="checkbox"/> Quarterly; <input type="checkbox"/> Monthly  <input type="checkbox"/> This is a Three Year Fixed Rate Policy	Premium for Increased Limits Part Two, if applicable	\$
	Total Premium Subject to the Experience Modification	\$
	Premium modified to Reflect Experience Mod. Of                      See Schedule	\$
	Other Premium Charges	\$
	Total Estimated Standard Premium	\$
	Premium Discount, if applicable	\$
	Expense Constant Charge	\$
	 Total Estimated Premium	 \$
	 Other Premium Charges	 \$
	Total Estimated Annual Premium	\$

Minimum Premium \$ \_\_\_\_\_ Deposit Premium \$ \_\_\_\_\_

Name of Producer:

Producer Address:

Countersigned By \_\_\_\_\_

Authorized Representative

Date

THIS INFORMATION PAGE WITH THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY  
AND ENDORSEMENTS, IF ANY, ISSUED TO FORM A PART OTHEROF, COMPLETES THE ABOVE NUMBERED POLICY.

CLASSIFICATION OF OPERATIONS	CODE NO.	Estimated Total Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premiums	
				Subject to Modification	All Other

**Item 1    Extension Schedule**

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**Schedule of Named Insured and Locations**

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**LOCATIONS:**

**FEIN #:**

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**Insured:  
Policy Number:  
Effective Date:**

**Item 3.D. Extension Schedule**

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**Schedule of Forms and Endorsements**

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Form Number:   Edition:   Description:

---

**Insured:**  
**Policy Number:**  
**Effective Date:**

<i>SERFF Tracking Number:</i>	<i>PERR-125627554</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Guarantee Insurance Company</i>	<i>State Tracking Number:</i>	<i>#? \$50</i>
<i>Company Tracking Number:</i>	<i>GIC-WC-AR-08-F</i>		
<i>TOI:</i>	<i>16.0 Workers Compensation</i>	<i>Sub-TOI:</i>	<i>16.0004 Standard WC</i>
<i>Product Name:</i>	<i>Policy Jacket - Dec page revision</i>		
<i>Project Name/Number:</i>	<i>GIC-WC-AR-08-F/GIC-WC-AR-08-F</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number:	PERR-125627554	State:	Arkansas
Filing Company:	Guarantee Insurance Company	State Tracking Number:	#? \$50
Company Tracking Number:	GIC-WC-AR-08-F		
TOI:	16.0 Workers Compensation	Sub-TOI:	16.0004 Standard WC
Product Name:	Policy Jacket - Dec page revision		
Project Name/Number:	GIC-WC-AR-08-F/GIC-WC-AR-08-F		

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Uniform Transmittal Document-Property & Casualty	<b>Review Status:</b>	Approved	05/05/2008
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### Comments:

### Attachments:

FFS.pdf  
PCTD-F.pdf

<b>Satisfied -Name:</b>	Filing Memorandum, Letter of Authorization	<b>Review Status:</b>	Approved	05/05/2008
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### Comments:

### Attachments:

Filing Memorandum.pdf  
loa.pdf

**FORM FILING SCHEDULE**

(This form must be provided ONLY when making a filing that includes forms)  
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

<b>1.</b>	<b>This filing transmittal is part of Company Tracking #</b>	<b>GIC-WC-AR-08-F</b>			
<b>2.</b>	<b>This filing corresponds to rate/rule filing number</b> (Company tracking number of rate/rule filing, if applicable)	<b>N/A</b>			
<b>3.</b>	<b>Form Name /Description/Synopsis</b>	<b>Form # Include edition Date</b>	<b>Replacement or Withdrawn?</b>	<b>If replacement, give form # it replaces</b>	<b>Previous state filing number, if required by state</b>
01	Workers Compensation and Employers Liability Insurance Policy	WC 00 00 00 A	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02	Workers Compensation and Employers Liability Insurance Policy Information Page	WC 00 00 01A	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

# Property & Casualty Transmittal Document


<b>1. Reserved for Insurance Dept. Use Only</b>	<b>2. Insurance Department Use only</b>	
	a. Date the filing is received:	
	b. Analyst:	
	c. Disposition:	
	d. Date of disposition of the filing:	
	e. Effective date of filing:	
	New Business	
	Renewal Business	
	f. State Filing #:	
	g. SERFF Filing #:	
h. Subject Codes		

<b>3. Group Name</b>	<b>Group NAIC #</b>
N/A	N/A

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Guarantee Insurance Company	FL	11398	22-2222789	

<b>5. Company Tracking Number</b>	<b>GIC-WC-AR-08-F</b>
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**Contact Info of Filer(s) or Corporate Officer(s)** [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Lois Pimentel c/o Perr&Knight 881 Alma Real Dr, Ste. 205 Pacific Palisades, CA 90272	State Filings Analyst	888.201.5123 x162	310.230.8529	doi@perrknight.com
7.	Signature of authorized filer				
8.	Please print name of authorized filer		Lois Pimentel		

**Filing information** (see General Instructions for descriptions of these fields)

<b>9. Type of Insurance (TOI)</b>	16.0 Workers Compensation
<b>10. Sub-Type of Insurance (Sub-TOI)</b>	16.0004 Standard WC
<b>11. State Specific Product code(s)</b> (if applicable)[See State Specific Requirements]	N/A
<b>12. Company Program Title</b> (Marketing title)	N/A
<b>13. Filing Type</b>	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
<b>14. Effective Date(s) Requested</b>	New: 06/01/2008      Renewal: 06/01/2008
<b>15. Reference Filing?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>16. Reference Organization</b> (if applicable)	N/A
<b>17. Reference Organization # &amp; Title</b>	N/A
<b>18. Company's Date of Filing</b>	May 1, 2008
<b>19. Status of filing in domicile</b>	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

**Property & Casualty Transmittal Document—**

<b>20.</b>	<b>This filing transmittal is part of Company Tracking #</b>	<b>GIC-WC-AR-08-F</b>
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<b>21.</b>	<b>Filing Description</b> [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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On behalf of Guarantee Insurance Company ("Guarantee") we are submitting this form filing. Guarantee has recently re-domesticated from South Carolina to Florida. The enclosed documents reflect the current address and phone number of Guarantee.

For completeness, we are submitting all of the extensions and schedules that accompany the declarations page. As a member of NCCI, Guarantee has elected to utilize the NCCI forms that have been submitted and approved in your state on Guarantee's behalf. This filing supplements the NCCI forms.

Guarantee proposes to implement this filing for all policies effective on or after June 1, 2008.

The rate impact of this filing is 0.0%.

Enclosed is authorization for Perr&Knight to submit this filing on behalf of the Company. All correspondence related to this filing should be directed to Perr&Knight. The Company has prepared the forms contained in this filing. If there are any requests for additional information related to items prepared by the Company, we will forward the request immediately to the Company. We will submit the Company's response to your attention as soon as we receive it.

Please do not hesitate to contact us should you have any questions or concerns.

<b>22.</b>	<b>Filing Fees</b> (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
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**Check #:** 102653

**Amount:** \$50.00

**Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.**

**\*\*\*Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

**GUARANTY INSURANCE COMPANY  
WORKERS COMPENSATION**

*FILING MEMORANDUM*

On behalf of Guarantee Insurance Company ("Guarantee") we are submitting this form filing. Guarantee has recently re-domesticated from South Carolina to Florida. The enclosed documents reflect the current address and phone number of Guarantee.

For completeness, we are submitting all of the extensions and schedules that accompany the declarations page. As a member of NCCI, Guarantee has elected to utilize the NCCI forms that have been submitted and approved in your state on Guarantee's behalf. This filing supplements the NCCI forms.

Guarantee proposes to implement this filing for all policies effective on or after June 1, 2008.

The rate impact of this filing is 0.0%.



May 7, 2007

To Whom It May Concern:

Perr & Knight, Inc. is hereby authorized to submit rate, rule, and form filings on behalf of Guarantee Insurance Company. This authorization includes providing additional information and responding to questions regarding the filings on our behalf as necessary. This authorization is deemed to be in effect until rescinded on writing.

Please direct all correspondences and inquiries relate to this filing related to this filing to Perr & Knight, Inc. at the following address:

Perr & Knight, Inc.  
1200 North Federal Highway, Suite 309  
Boca Raton, FK 33432  
Tel: (561) 416-3992  
Fax: (561) 416-3167

Please contact me at (954) 670-2901 if you have any questions regarding this authorization.

Sincerely,

Steven M. Mariano  
President, Chief Executive Officer